Community Homes of Intensive Care and Education Limited

Winton Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Winton Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Winton Lodge was registered for up to nine people. There were six young adults living and receiving care and support from staff at Winton Lodge at the time of our inspection. People had a variety of care and support needs related to maintaining their mental well-being, learning disabilities or autistic spectrum disorders. The people living in Winton Lodge had some difficulties communicating their needs or managing their emotions. This meant at times they could become agitated and anxious. At times this resulted in verbal and physical aggression towards the property, themselves, staff and other people sharing the home.

This unannounced inspection took place on the 5 and 7 March 2017. We made further telephone calls to gather evidence up until 14 March 2018 and received further evidence from the provider following our visits to the home. The inspection was planned as a focussed inspection in response to information received by the Care Quality Commission about potential risks to people. We identified concerns regarding people's safety and this meant the inspection was extended to a comprehensive inspection in line with our published methodology.

There was a registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were living with others who may cause them harm and had difficulties managing their own emotions. One person and the relative of another person did not always feel safe as a result of this. Whilst we found inconsistent care had increased the likelihood of harm in one instance, staff understood the risks people faced and how to reduce these risks. Measures to reduce risk reflected the person's preferences. Staff also knew how to identify and respond to abuse and told us they would whistleblow if it was necessary. However, a potential safeguarding occurrence had been reported to managers and this had been dealt with internally but agencies responsible for monitoring safeguarding had not been informed.

Staff encouraged people to make decisions about their lives. However, care plans did not always reflect the care that was being delivered or how it was developed within the framework of the Mental Capacity Act 2005. People were at risk of receiving inconsistent care that was not in their best interests or was overly restrictive. We have made recommendations about recording. Deprivation of Liberty Safeguards had been applied for when necessary.

People were supported by safely recruited staff who were committed, kind and enthusiastic but did not have the skills, knowledge or experience to fully undertake their roles. This had led to people being put at

risk of harm. Of the workforce employed at the home, 50% had been recruited within the last 12 months. This meant that they had or were in the process of undertaking their induction programme and were developing their skills and knowledge. Staff told us they felt supported in their roles and had taken training that provided them with some of the necessary knowledge and skills. We have made a recommendation about staff training.

Oversight structures and ethos of care were clearly communicated. However, quality assurance systems had not been effective in identifying the issues identified during our inspection.

People and relatives and professionals felt that they were listened to. Their views were considered and acted upon although this action may not have been timely.

The environment was clean and maintained although damages and changes made during incidents were not always addressed quickly. This served as an unnecessary reminder of events for people.

Everyone described the food as good and there were systems in place to ensure people had enough to eat and drink.

People had access to activities that reflected their preferences, including individual and group activities. There were plans in place to further develop the activities available to people.

People were largely positive about the care they received from the home and told us the staff were kind. Staff were cheerful and treated people and visitors with respect and kindness throughout our inspection.

There were breaches of regulation with respect of safe care and treatment, staffing, safeguarding and the governance of the service. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People were not always supported by staff who had the necessary skills and knowledge.

People had difficulties managing their emotions and lived with other people who also struggled with this. They did not always feel safe as a result of this.

People were supported by staff who spoke competently about how they reduced these risks but some interactions between staff and people did not reduce these risks.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not always have knowledge necessary to deliver effective care.

Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately but where additional restrictions were in place they had not always been considered in line with MCA.

People who were able to consent to their care had done so and told us they directed the care they received.

Is the service caring?

Good

The service was caring.

People received compassionate and kind care from staff. Staff developed relationships with people and took the time to get to know them individually. They treated all people, visitors and colleagues with dignity and respect.

People and their relatives were listened to and felt involved in making decisions about their day to day care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People, and relatives, were confident they were listened to and knew how to complain if they felt it necessary.

Actions were not always taken in a timely manner.

Recording omissions and inaccuracies made it difficult to review people's experience of care. People enjoyed access to a range of activities and this was being developed.

Is the service well-led?

Requires Improvement

People, relatives and staff had confidence in the management and spoke highly of the support they received.

There were systems in place to monitor and improve quality including seeking the views of people and relatives. These had not been effective in highlighting the concerns identified during our inspection.

Winton Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 5 and 7 March 2018 and was unannounced. We made further telephone calls to gather evidence up to 14 March 2018.The inspection team was made up of two inspectors.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information received from other parties. The provider had submitted a Provider Information Return (PIR) prior to their most recent inspection in 2017. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection and ensured we gathered up to date information whilst inspecting the service.

During our inspection we observed care practices, spoke with three people living in the home, three relatives, six members of care staff, two members of the provider's positive behavioural support team, the registered manager overseeing the service and the provider's area manager. We also looked at records, including medicines administration records, related to six people's care, and reviewed records relating to the running of the service. This included five staff records, quality monitoring audits and accident and incident records. Following the inspection we asked the registered manager to send us information about staff deployment, policies, training and care delivery. We received this information as agreed.

We also spoke with or received feedback from two social care professionals and three healthcare professionals who worked with the service.

Requires Improvement

Is the service safe?

Our findings

People did not always feel safe. They were living with other people who had difficulty managing their emotions and there had been an increase in incidents of aggression over the previous months due to difficult periods in people's lives. One person said: "I don't always feel safe with staff." And then described an incident where they had been hurt by another person living in the home the night before the inspection. Staff were trained to respond to incidents of aggression using an accredited positive behaviour support system. The organisational philosophy was to reduce incidents of this nature through positive behaviour support. This is a research based holistic approach that focusses on people as individuals and creates opportunities for people to live meaningful lives.

We found mixed evidence about the application of this approach. People all had plans providing guidance around what might cause a person to experience difficult emotions and how they could be supported to manage these. These were developed with information provided by people, relatives, professionals and staff and included guidance around what helped people to be in control of their emotions such as activities they found enjoyable, consistency and structured time and detailed information about how staff should intervene physically to protect people's safety if this became necessary. We heard from staff and relatives about the impact of planned responses being successful in helping people live their lives for example people had undertaken voluntary work and been on holidays. Staff spoke positively about what helped people stay calm. However, we also saw that people did not always have support that reflected the approaches outlined in their plans and this had an impact on their well-being.

One person had become upset and physically hurt another person living in the home. Staff reflected in their reporting that guidance had not been followed prior to this and known triggers that made the person upset had occurred and we could not find any record of the specific guidance referred to in the person's care plan. How staff supported a person to manage their use of their time had been the subject of recorded discussions since September 2017. There was a record made in the home's communication book after a meeting of family and professionals in December 2017. This record highlighted the need for consistency but did not reflect the current practice amongst some staff. It stated: "Please be consistent" and "hopefully with consistency this will be a useful strategy to reassure (the person) and reduce behaviours." This memo had been initialled by four of the 19 staff team employed at Winton Lodge at the time of our inspection to show they had read the memo. The guidance did not reflect current practice. Staff we spoke with had different views of what the current guidance was. The registered manager gave an account of the purpose and description of the staff approach and acknowledged that this guidance was not recorded anywhere. The staff were therefore following an unwritten and inconsistently interpreted approach. This did not reflect good practice in the support of people with autistic spectrum disorders and the effectiveness of this approach could not being monitored. Following the inspection site visits the area manager sent us through guidance that had been put in place and we were assured that consistency would be addressed. We have not been able to check the effectiveness or sustainability of this change.

We recommend you undertake a review of care delivery to ensure it is reflective of agreed care plans.

We asked about strategies that helped the person calm down and the registered manager referred to a calendar with two events recorded on it. They told us "They know they have to be good to … (go to the event)". They then clarified this and said it could be put back. Another member of staff told us that the person could be reminded to be good and that this sometimes stopped them hitting others. They told us: "(they) think (they) won't go but we know (they) will". We spoke with the registered manager and area manager about this and were shown that in a meeting a relative of the person had explained the person responded to rewards and identified that this must be used sparingly and realistically. They also sent us information about positive reinforcement. The application of the rewards discussion, however, did not reflect positive behaviour approaches and was not recorded in the person's positive behaviour support plan. Reference to the removal of a reward is a sanction for behaviour. The use of threats of sanction had been addressed with staff at a meeting in January 2018. This discussion had had not led to the identification of this approach as potentially punitive and restrictive.

There were a range of policies in place to support good safeguarding practice. The procedures reflected current legislation and referred to where staff could locate the latest contact details for local safeguarding teams. Staff had received training in how to follow the safeguarding process and were able to describe how they would report suspected abuse. They were confident concerns would be taken seriously by managers. One member of staff told us: "I could call the police, safeguarding or care managers if necessary." Staff all told us they had a 'whistleblowing card' and knew how to raise concerns about practice.

Where people had been hurt by other people living in the home these events had been reported to the safeguarding authority and CQC. An incident where an untrained member of staff had restrained a person had not been reported to safeguarding or CQC. We raised this as a safeguarding alert as it could not be described as proportionate restraint. The person also spoke with paramedics the next day and identified that they had experienced pain after a further restraint the next day. We spoke with the registered manager and area manager about this. They told us that they did not feel it needed to be raised as a safeguarding as there had been "no harm caused or intended". The incident was addressed within the organisation only and information provided to the person's local team did not refer to the untrained staff restraint.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People went out during our visits and were supported to make their meals and undertake household responsibilities as appropriate. However, we also needed to find staff for a person who was distressed. . During the time they were distressed and standing on the landing another person who could become aggressive when distressed was also in the area. We called for staff alongside the distressed person but no staff came. We went to find staff and found them in the office and kitchen. When made aware the person wanted their assistance a member of staff went to provide this . Staffing levels were determined with a dependency tool that reflected the support people needed. However it was not clear how this translated into rotas and staff allocated to work with each person.

Staffing deployment should reflect the needs of people and ensure that the staff working have the training and experience required to support people. The staff deployment at Winton Lodge did not always reflect the needs of people. Although staff were individually flexible and committed ensuring that people went out to events they wished to attend and staying on to support their colleagues and people through difficult times, the rota did not reflect the sleep patterns of people living in the home. People living in the home were younger adults and half of them regularly went to bed at or after midnight. Staffing, however, reduced to two waking night staff at 9:30pm. We asked why this was and were not shown that this reflected the needs of people. On eight nights in February 2018 the overnight staffing was reduced to a waking night and a sleep in

due to staff availability. We saw that a generic risk assessment had been completed which determined that staff needed to have first aid and medicines training in order to reduce the risks. There were three nights when neither the sleep in nor waking staff had undertaken practical first aid training.

There were 10 nights during February 2018 and the first week of March 2018 when the staff working at night, either both waking or one sleep in and one waking, could not give medicine because they had not received the training they needed to do so. On the night before our second visit this resulted in a person staying up for a large part of the night as they had requested PRN medication. They told us about this the next day saying they had requested a medicine they take to aid sleep. There was an agreed protocol in place that staff could determine when they took PRN medicine prescribed to reduce agitation. This protocol did not extend to medicines prescribed to aid sleep or to reduce pain. Staff told us that on another occasion a person had requested their PRN medication during an occasion when they became aggressive. They waited approximately 15 minutes for the on call to attend to provide this. This meant they had to wait whilst extremely agitated which had an impact on both them and others.

The area manager put a plan in place to ensure that a trained member of staff was available at nights at the end of our inspection. There were two nights in February 2018 when due to the use of agency staff there were not two members of staff on at night who had been trained in the use of physical intervention as outlined in people's care plan. There were 11 nights in February 2018 and the first week of March 2018 when the staff working had not undertaken any practical fire training. This failure to deploy appropriately trained staff put staff and people at risk of harm.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a recruitment procedure that ensured recruitment checks were in place. Staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check. Staff had access during their induction to training in safety systems, processes and practices such as in moving and handling, fire safety and infection control.

Staff understood their responsibilities to ensure infection control was effectively managed and we saw they used appropriate protective clothing when supporting people with personal care or cleaning. People's rooms and communal areas were cleaned throughout our inspection.

Equipment owned or used by the registered provider were suitably maintained. Effective systems were in place to ensure equipment was regularly serviced and repaired as necessary.

Staff who administered medicines had undertaken training and had their competency assessed. Medicines administration was not effective or safe. This was because staff responsible for making decisions about the use of medicines that are used as required (PRN) were not always trained to give these medicines and it was not always clear why these medicines had been administered. For example, a person's daily records indicated that they were calm and there had been no concerns but they were administered PRN due to them being 'agitated'. It would not be possible to review the effectiveness of this medicine, and how the decision was made by staff, from these records. We spoke with the registered manager and area manager about this and they assured us they would address the recording of PRN medicines and ensure that medicines training was delivered to all night staff.

There was a personalised approach to people's day to day medicines administration and people were encouraged to take a lead in how and where they took their medicines. Medicines were kept tidily and

according to manufacturer's guidance and a record kept of when they were opened.

Some people took medicines that required stricter controls by law. These checks were robust and we saw they were stored correctly.

Accident and incident reports were reviewed and actions taken as necessary. A member of the provider's positive behaviour support team reviewed incidents where physical intervention had been used and the lead of this team undertook regular reviews. These had included records of medical assistance being sought for people.

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Staff told us they were confident if they had concerns the manager and operations manager would listen and take suitable action.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made where appropriate.

MCA assessments and best interests decisions were not always in place to determine the least restrictive way to provide people with the care and support they needed. Some assessments and best interests decisions were recorded for people, including specific decisions such as whether staff should administer their medicines. However, restrictive care practices had not always been considered by following this process. For example, the unwritten approaches to the person's use of their time. Some records had not been updated to reflect changes in restrictions. For example, one person's plan said it was a necessary restriction that their monies were looked after and this was not the case. Some MCA assessments and best interests decisions did not reflect the primary decision but rather the response planned by the home. For example, did a person understand the reasons their medicines were being administered by staff rather than the primary question as to whether they had the capacity to manage the medicines themselves. This missed out an important step and meant that people may have restrictions in place that were not necessary for them as individuals.

We recommend you seek guidance from an appropriate source and review your recording around the Mental Capacity Act 2005 to ensure it promotes the least restrictive principle of the Act.

Some staff had received training in MCA and DoLS and demonstrated an understanding to the principle of gaining consent before offering support and care. They told us they checked with people before providing any care and explained what they were doing. We saw that people were offered choices such as where they wanted to sit for meals and whether to get involved with activities.

Records showed staff were expected to undertake training to enable them to carry out their roles. For example, care staff received mandatory training in PROAct-SCIPr-UK©, first aid, fire safety, infection control and safeguarding. Some training had not been completed or refreshed. Department of Health guidance on developing the workforce to reduce restrictive intervention highlights the importance of staff being able to apply the Mental Capacity Act alongside their training in physical interventions. Staff covered the Mental Capacity Act 2005 as part of their physical intervention training and were also expected to undertake a separate training covering the Act in more detail. There were three nights in February 2018 and the first week of March 2018 when no staff working had undertaken this additional training and the staff did not understand the principles of the MCA and how it framed their work.

Staff were trained in the use of PROACT-SCIPr-UK ©. This is a person centred approach designed to reduce the need for physical intervention that includes training staff in safe restraint. PROACT-SCIPr-UK© identify that refresher training should be taken annually to ensure standardisation. They acknowledge that in exceptional circumstances this cannot be achieved. The organisations policy states: "Managers will ensure that all employees undertake refresher training every twelve months and certainly no late (sic) than fifteen months after their last training." Five members of the staff team of 19 had not undertaken their refresher in the last twelve months. This represented a quarter of the team and did not reflect good oversight of an essential training need.

Three staff told us they had not had training about how autism can impact on people. Most of the people living at Winton Lodge had a diagnosis of autism or autistic spectrum disorder (ASD). We reviewed training records and saw that the majority of the staff team had not received training and this meant that there were frequent occasions when no staff on duty had undertaken this training.

We recommend you follow appropriate good practice guidance about staff understanding of autism and how it impacts on people they support.

Staff told us they felt supported by their colleagues, the manager and the operations manager. They all commented on how accessible the positive behaviour support team was. One member of staff reflected on the support of the whole staff team saying: "We are getting to be a strong team." Another member of staff commented: "I really enjoy the team." There was a system in place for staff to take part in regular supervision and appraisal sessions. This gave them an opportunity to discuss any concerns, highlight any training needs and discuss their career.

The staff team had changed substantially in the last year with almost half the team joining during that time period. Some of these staff were new to care work and had started the Care Certificate. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. Visiting professionals commented on the staff skills. All highlighted the kindness and commitment of staff but gave examples of times they had seen evidence of a lack of experience impacting on people's care. For example being too close to someone or touching someone in an agitated state. Following the inspection the provider has implemented visiting professional feedback forms to gather these comments from other stakeholders and act upon them. We also saw records that reflected staff getting involved in a disagreement with a person who was agitated. This did not reflect a specific care plan and was indicative of not understanding impact of agitation on information processing.

People were supported with their day to day health needs in conjunction with health care professionals. Records showed that people had regular contact from a range of health professionals such as: nurses, GP's, psychologists and consultants. People's views, histories and lifestyles were respected as part of the support they received to maintain their health. Health care professionals raised concerns that they did not always get the information they needed.

The physical environment was being used in a way that supported people to maintain relationships and spend their time meaningfully. People used communal areas and their bedrooms and there was access to secure outdoor spaces where seating and planting provided a pleasant environment. Where the environment had been changed or damaged during an incident this was not always addressed quickly. For example, there was a hole in the wall and ornaments had been removed from a communal area. Both of these events had happened more than a week before our visits but had not been addressed. These were potentially visual reminders of difficult times for people living in the home. Staff had, however also

considered environmental impacts on people and made efforts to ensure their private space reflected their individual needs.

Before moving into the service people had their needs assessed across a wide range of areas. This assessment process identified initial support needs and enabled the service to determine whether or not they could meet those needs. Staff described how people were treated with respect and without judgement. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. Admission assessments were used to develop a care plan for the person. There were prompts in the care plan paperwork that set out areas to cover and this promoted care planning in line with current legislation, standards and good practice guidance such as ensuring risk assessments were kept under review.

People were involved in decisions about what they ate and drank and this included any dietary, cultural or religious needs. They were mostly positive in their feedback about the food: One person said: "We have a meeting about the food." Another person said: "The food nice." Meals were flexible to meet people's needs and people chose where they ate. People took it in turns to help prepare food and this encouraged positive relationships. People fed back about the food frequently at menu planning meetings.

People were encouraged to have a balanced diet that supported their health and well-being whilst respecting their rights to make unwise decisions. There were systems in place to ensure safe swallow plans drawn up by a speech therapist were followed but no one needed this support at the time of our inspection.

The Food Standard Agency had awarded a top rating of five following an inspection in November 2015. This meant they had met standards of hygiene and safety at this time. The kitchen was clean at the time of our inspection and food stuffs were stored safely.

Good

Is the service caring?

Our findings

The service was caring. Professionals, staff, relatives and people liked the registered manager and made comments like : "they are a lovely kind person." And she is "a super nice lady". This kindness was also evident in the majority of the staff team who described people in positive ways acknowledging the challenges within a context of respect. One relative commented on how 'lovely' their relatives key worker was. Another told us the staff were fantastic; highlighting the youth and energy in the team as having a positive impact on their relative. People were relaxed with staff the majority of the time and shared in familiar banter and discussed shared experiences throughout our visits.

Staff told us they enjoyed their work and enjoyed spending time with the people they supported. They were kind, compassionate and caring and spoke with enthusiasm for their work. They also spoke with respect for their colleagues, making comments such as: "It is a great team."

Throughout our inspection there was a welcoming atmosphere in the home. We observed staff interacting with people in a caring, respectful and compassionate manner. For example, in one conversation a person kept referring back to a singular issue, staff paid attention to people during communication reflecting and validating their concerns.

Whilst attentive the staff also respected the person's space and how they liked to be supported. For example one person preferred their day to be structured and for plans to be followed out without deviation. Staff supported them to engage with our inspection whilst asserting their own wishes and priorities.

People were encouraged to use all the communal areas in the main house to relax and engage in activities individually or with others. Some people sat in the lounge chatting with staff or doing energetic dance based exercise. Another person used the space differently moving between spaces and seeking staff out regularly for reassurance that was provided each time.

We spoke with staff about how people communicated. They described how a combination of their facial expressions and eye movements alongside verbal communication provided them with clear information about a person's mood state. They also referred to communication tools used to aid choice and communicate routine. For example one person used a 'now and next' book to reassure them of the structure of their day.

Staff respected people's privacy and dignity. Staff knocked on people's doors before entering and did not share personal information about people inappropriately during our visits. People's bedrooms were personalised with belongings, such as hobbies, pets, photographs and ornaments. People were encouraged to make decisions about their appearances, for example what they wished to wear. People appeared well cared for and staff supported them with their personal appearance in ways that promoted their dignity.

Staff supported people to maintain their independence and the impact of this support was evident throughout our inspection. People were encouraged to maintain and develop skills to help them manage

their own day to day lives. Staff were not rushed and could describe what parts of daily life people could undertake themselves.

We heard about support for people's personal relationships. People were supported to contribute meaningfully to their family relationships both at special events and as part of the usual rhythm of their lives. One person had attended an event on relationships however we also saw a record that indicated they had been told by staff that people "don't have relationships in the house". We discussed with the registered manager, staff and members of the positive behaviour support team the extent to which people were supported to retain autonomy and dignity in their personal lives. They identified that expression of sexuality would be responded to with specific intervention where it was deemed necessary as opposed to expression of their human rights. They also identified a situation where a person had been supported by staff regarding a relationship. Some staff had received training about relationships as a part of wider training subjects. This had not translated into confident care practice.

We recommend you ensure staff receive appropriate training to ensure they can support people to express their sexuality confidently.

Requires Improvement

Is the service responsive?

Our findings

Staff described people's needs without judgement and emphasised people's individuality in all their discussion with us. Care plans had been reviewed and covered a range of areas including personal care and aggression. They were individualised with information about people's likes and dislikes and referred to people who were important in people's lives. Care plans and records were not reflective of all current information and we saw that guidance from other professionals was not added in a timely manner. There was a risk that people would not receive safe care and treatment as a result of this. Staff were aware of each individual's care plan, however, they told us they learned about people's needs from discussion with colleagues. Whilst vital for developing reflective practice that was adapted to people's needs, the failure to record approaches increased the risk that people would not receive appropriate care and treatment. We spoke with the registered manager about this. They acknowledged the importance of agreed and consistent approaches.

Where care plans had been updated the reasons for the change were recorded. This meant it was possible to monitor people's changing needs. We also heard that a new care plan format was being introduced which promoted person centred approaches. This was beginning to be implemented at the time of our inspection.

There was on going work to ensure that people had meaningful things to do with their time. During our visits we saw people went to the cinema, on a bike ride, shopping and did colouring. We also observed that people spent a lot of time not engaged in activity with staff support. It is important that people have time to relax and to determine how to spend their time independent of support however for people who experience heightened risks to their emotional well being it is important that their needs for activity are met. Records and observations reflected sustained periods without activity and this observation was also reflected by professionals and two relatives. Relatives reflected that staff had gathered information about what their loved one enjoys. However, two relatives expressed concern that this did not always lead to activity based on that information. For example, one relative commented that the staff had recorded an activity their loved one enjoyed last year but they had been asked if they enjoyed this activity again in the past month and they had not yet done it. We found daily recording by staff was not always complete or didn't identify what had happened during a day. For example, one person was recorded as liking to be busy and active. We reviewed a week of their activities and found that no activities were recorded on some days. The provider has assured us that activities did take place on these days but acknowledged that there were gaps in the recording on some days. We spoke with the registered manager who explained that an activities coordinator was being appointed to support staff and people with activities. There were examples of positive experiences that this member of staff could build on.

Recording about people's experiences was not always accurate with information about times when people had become agitated or anxious. It was not always clear on daily and activities records and other pertinent information if information had been recorded or reviewed. This made it difficult to determine if people were receiving the care and support they needed to support their general well being.

We recommend that you seek appropriate guidance and review your oversight of records to ensure that you

can monitor people's experience of their support holistically.

Any communication needs were identified at assessment before people moved into the service. These were recorded in the care plan so staff had information about people's needs. Staff told us that no one living at Winton Lodge currently used any form of signing and some staff had received training when a person living in the house had used a form of sign language. Social stories were developed by the positive behaviour support team to support people at times they found difficult. Social stories are a way of presenting information to help people with an autistic spectrum disorder to understand and process information. These had been successful.

There was a system in place for receiving and investigating complaints. People and relatives confirmed they knew how to make a complaint and felt any concerns raised would be dealt with. Where learning needs were identified it was clear that these had been acted on with individual staff members. Professionals reflected that senior staff were responsive to concerns being raised.

Requires Improvement

Is the service well-led?

Our findings

The registered provider had a quality assurance process that included regular provider visits to the home. The registered manager and senior staff also undertook audits. We found that these had not been effective in rectifying the inconsistencies, inaccurate recording and staff deployment concerns identified in this inspection. Following the inspection the area manager sent information through in response to concerns raised. They introduced a sleep in member of staff to give medicines if night staff were not trained and they put in place guidance about the person's use of their time. Other information provided was sent in support of actions taken within the home that we have identified as of concern. The systems in place did not effectively assess, monitor and improve the safety and quality of the service.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been recent changes in the senior team and a new deputy manager had been recently appointed to the team. People and staff had been kept informed about these leadership changes. An interview was being undertaken of a management role during our inspection and the area manager asked a person if they would be coming to meet the candidate. Whilst not a part of the formal interview process; this reinforced that the person's views were valued.

The manager and area manager were visible within the service so were aware of day to day issues brought to their attention by staff. People reacted with familiarity to them and this was reciprocated. One person told us: "I like (registered manager)." The senior management team spoke highly of the staff team and told us they were motivated to do the best for people. Whilst it was a developing team, with a high proportion of staff new to care, the staff spoke highly of each other and were confident that everyone they worked with had people's best interests at heart. Staff spoke with pride about their own work and that of their colleagues in trying to secure good outcomes for people. They told us they were part of a "good team". Most relatives also spoke highly of the staff team.

The service had a clear management structure with senior staff working within the home and the registered manager reporting to their line manager from the provider organisation. Within the home one member of staff was identified as the person in charge and staff members were clearly allocated responsibilities. The positive behaviour support team fitted into this structure supporting staff with reflective practice, offering support, developing care plans and maintaining oversight of incidents and the use of physical interventions. This input was vital to the service but we identified examples of communication between the teams not being effective in securing consistent approaches within a positive behaviour support approach.

Whilst the oversight systems had not been effective in identifying the issues highlighted during our inspection, the staff were unanimously positive about the arrangements and told us they felt supported and this contributed to their job satisfaction. One member of staff said: "I really enjoy working here" Another member of staff commented on the accessibility of management saying: "(Registered manager) is always available."

The registered persons had ensured relevant legal requirements, including registration, safety and public health related obligations had been complied with.

The approach to quality assurance included a surveys and feedback from people. People were asked to comment on the service at regular meetings. Relatives told us they were able to comment on all aspects of the service.

Records were stored securely and there were systems in place to ensure data security breaches were minimised. Staff had log ons to access computer based records and rooms containing records were locked when not occupied by staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from improper treatment because systems and processes were not operated effectively. Regulation 13 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to monitor, assess and mitigate risks to the health , safety and welfare of people and to improve quality. Records were not always accurate. Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficiently trained staff were not deployed to support people. Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014